Congress of the United States
Washington, DC 20515

April 24, 2014

The Honorable Eric Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

We write today to express our deep concern regarding the allegations that delays in care at the Phoenix VA Health System (PVAHCS) caused the deaths of Arizona veterans. We understand that the VA Office of Inspector General is investigating these allegations. We request we be made aware immediately of the findings of this investigation, those responsible be held accountable and action is taken to ensure that veterans in Arizona receive timely access to the best possible care.

The allegations that veterans in Arizona failed to receive timely access to care and that management at the VA facility in Phoenix intentionally misrepresented wait times and shredded evidence are disturbing. Reports claim that as many as 40 veterans died as a result of delays in obtaining care.

Did in fact, 40 veterans die as a result of delays in care? Did the PVAHCS intentionally misrepresent wait times? Were there two lists as asserted by Dr. Foote and is this practice still in use? What is the actual wait time for care at the PVAHCS? Arizona veterans and their families deserve answers to these questions, and the individuals responsible for misconduct must be held accountable.

Again, we request a response to these allegations and swift action to ensure that Arizona veterans have timely access to the best possible care. Thank you for your attention to this matter and we look forward to your prompt response.

Sincerely,

Ron Barber
Member of Congress

Ann Kirkpatrick
Member of Congress

Kyrsten Sinema
Member of Congress